# LIMITED BENEFIT GROUP SUPPLEMENTAL INSURANCE
# MEMBER CLAIM FORM

**Submitting your claim**
Submit your claim the way you like via mail, email, online portal, or fax:

**Bay Bridge Administrators, LLC**
**P.O. Box 161690**
**Austin, TX 78716**

**Email: claims@bbadmin.com**
**Portal: portal.bbadmin.com**
**Fax: 512-275-9350**

This form can be found on our website at www.wellfleetinsurance.com or bbadmin.com

**Questions?**
If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact our Customer Service Center at

- 1-855-900-4777, 8:00 AM to 5:00 PM CST
- claims@bbadmin.com

**Please read the following instructions and complete this form carefully:**

1. Completely fill out Parts 1 and 2 (Part 3 is optional).
2. Sign and date Part 4.
3. Remember to provide your Social Security Number and a copy of the Explanation of Benefits (EOB) from your major medical plan.
4. Attach a copy of your Explanation of Benefits (EOB) from your provider or hospital. The EOB will contain the amount your primary medical plan applied to your deductible, co-insurance, and/or co-pay.

   Please note that if the EOB does not contain a description of the services provided, we will also need the UB-04 Form from your hospital or CMS-1500 Form from your provider. These forms are the standard billing forms utilized by healthcare facilities and providers. Your documentation should provide complete information on:

   a) Provider's Name and Address
   b) Provider's Tax Identification and NPI Number
   c) Diagnosis Code (ICD-10)
   d) Charges/Cost of each treatment
   e) Procedure Code (CPT)
   f) Place of Service Code

5. Please submit your claim via mail, email, online portal, or fax provided on this form.

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

## PART 1. CERTIFICATE HOLDER INFORMATION (REQUIRED FOR ALL CLAIMS)

Full Name (As it appears on your Social Security card): _____

Date of Birth: _____ Social Security Number: _____

Mailing address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ E-mail: _____

Employer/Group Name: _____ Employer/Group Phone #: _____

Policy/Certificate Number: _____ This claim is for: ☐ Self ☐ Spouse ☐ Dependent

## PART 2. PATIENT INFORMATION (IF CLAIM IS FOR SPOUSE OR DEPENDENT CHILD)

Full Name (As it appears on Social Security card): _____

Date of Birth: _____ Social Security Number: _____

Relationship: _____ Phone #: _____

## PART 3. PROVIDER INFORMATION

**(ALL FIELDS REQUIRED FOR PAYMENT TO PROVIDER)**

Would you like this claim to be paid out to your Provider? ☐ Yes ☐ No

*If yes, please provide:*

Provider's Name: _____ Provider's Phone #: _____

Provider's Address: _____

Provider's NPI #: _____ Provider's Tax-ID #: _____

## PART 4. CERTIFICATION

Please read and sign below.

I acknowledge the receipt of the Department of Insurance Claim Fraud Statements provided with this claim packet. I have read the notices and am aware that it is a crime to fill out this form with facts I know are false or leave out facts I know are relevant and important. I certify that the answers given on this claim form are true, complete, and correctly recorded.

Please also remember to sign and date the attached authorization required to process your claim.

**Signature:** _____ **Print Name:** _____ **Date:** _____

## AUTHORIZATION TO RELEASE INFORMATION

Please read and sign below.

I authorize any: physician, hospital, company, employer or organization; to release the medical history, treatments or benefits payable for this claim to Bay Bridge Administrators, LLC or to persons or other organizations providing claims management services. A photocopy of this form shall be just as valid as the original.

**Signature:** _____ **Print Name:** _____ **Date:** _____

## FRAUD NOTICES

For residents of all states, other than those listed below: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware, Idaho, Indiana, and Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Tennessee, Virginia, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

WELLFLEET
WORKPLACE

BAY BRIDGE ADMINISTRATORS

# DIRECT DEPOSIT REQUEST AUTHORIZATION

**Name on Account:**

_____ ___ _____

First Name MI Last Name

**SSN:** _____

**Address on Account:**

_____ _____ ____ _____

Street Address City State Zip

**Phone:** _____ **Email:** _____

**Banking Information:**

_____

Bank Name

_____ _____ **Account type**: ☐ Checking

Routing Number (9 digits) Account Number ☐ Savings

**ATTACH VOIDED CHECK HERE**

I (we) authorize { BBA/Wellfleet} to initiate credit entries to my (our) account indicated above.

_____ _____

Authorized Signature Date

Please return form with filed claim to:


Name: Bay Bridge Administrators, LLC.
Address: P.O. Box 161690
Address: Austin, TX 78716
Phone: (855) 900-4777
Fax: (512) 275-9350
Email: claims@bbadmin.com